

Forms
Contact List
ES&H Instructions
Help Desk

**Find Subject Areas:**

Index ▼

Categories ▼

Alpha ▼

Show Side Menu

**Search Subject Areas & Legacy Documents:**

---

**Contents: Critiques**

 Effective Date: **March 2000**

 Point of Contact: [Quality Programs & Services Office](#)


---

Section	Overview of Content (see section for full process)
<a href="#">Introduction</a>	
<a href="#">1. Scheduling Critiques</a>	<ul style="list-style-type: none"> <li>• Designate critique leader.</li> <li>• Schedule meeting time and place.</li> <li>• Invite critique team members.</li> <li>• Bring relevant items to meeting.</li> </ul>
<a href="#">2. Conducting Critiques</a>	<ul style="list-style-type: none"> <li>• Give overview of critique process.</li> <li>• Collate facts, establish chronology, and evaluate event.</li> <li>• Send draft critique summary out for review.</li> <li>• Distribute final critique summary.</li> <li>• Complete required event reporting.</li> <li>• Complete follow-up activities.</li> </ul>
<a href="#">Definitions</a>	
<b>Exhibits</b>	
<a href="#">Events and Causal Factors Chart</a>	
<b>Forms</b>	
<a href="#">Critique Leader's Checklist</a>	
<a href="#">Critique Summary</a>	

## Training Requirements and Reporting Obligations

This subject area does not contain training requirements.

This subject area may or may not contain reporting obligations. See the subject area until obligations are listed here.

## References

[Occurrence Reporting and Processing System \(ORPS\)](#) subject area

[ES&H Standard 1.1.1, Price-Anderson Amendments Act Compliance Validation and Noncompliance Reporting Program](#)

[Investigation of Incidents, Accidents, and Injuries](#) subject area

[Lessons Learned](#) subject area

[Records Management](#) subject area

[Radiological Awareness Reports](#) subject area

## Standards of Performance

Managers shall, as appropriate, establish performance objectives, indicators and targets; conduct self-assessments to collect data and monitor progress; and evaluate the data to identify strengths and weaknesses in performance, and areas for improvement.

All staff and guests shall share information based on experience (e.g., lessons learned) to promote continuous improvement in business and work practices.

## Management System


This subject area belongs to the **Quality Management** management system.

[Back to Top](#)

**The only official copy of this file is the one online in SBMS. Before using a printed copy, verify that it is the most current version by checking the document effective date on the BNL SBMS website.**

1.4-092001-/standard/0y/0y00t011.htm

Send a question or comment to the [SBMS Help Desk](#)  
[Disclaimer](#)



Forms	Contact List	SBMS Instructions	Help Desk
-------	--------------	-------------------	-----------

**Find Subject Areas:**

**Show Side Menu** **Search Subject Areas & Legacy Documents:**

---

## Introduction: Critiques

Effective Date: **March 2000**

Point of Contact: [Quality Programs & Services Office](#)

---

Unless otherwise specified in a referenced document, this subject area provides guidance for conducting critiques of emergency preparedness exercises as well as for conducting critiques of events involving industrial safety or hygiene, conduct of operations, and/or areas of general programmatic breakdown. An event may be a single significant event and/or a combination of small events that show a trend toward a significant underlying problem. Staff are also encouraged to use the critique process to document noteworthy management practices and uniquely successful projects/work activities for inclusion in the [Lessons Learned](#) subject area.

The purpose of a critique is to capture the facts of an event, establish the chronology, and identify lessons learned information. It is designed to be "fact finding," not "fault finding," and is not used to blame employees for adverse consequences of the event. The facts documented through the critique process facilitate providing Laboratory management concise information pertaining to:

- the overall performance of management systems, programs, or processes;
- adherence to Laboratory policies, standards, procedures, and business goals;
- identification of causal factors contributing to observed weaknesses or anomalous performance; and
- noteworthy management practices and uniquely successful projects/work activities.


Critiques may become part of a formal investigation of complex accidents/incidents (which may be mandated by Laboratory senior management or required for reportable occurrences). All events that will be critiqued should be reviewed against [Occurrence Reporting and Processing System \(ORPS\)](#) subject area, for potential required occurrence reporting.

[Back to Top](#)

**The only official copy of this file is the one online in SBMS. Before using a printed copy, verify that it is the most current version by checking the document effective date on the BNL SBMS website.**

1.4-092001/standard/0y/0y00i011.htm

Send a question or comment to the [SBMS Help Desk](#)  
[Disclaimer](#)



[Forms](#)
[Contact List](#)
[SBMS Instructions](#)
[Help Desk](#)

**Find Subject Areas:**

[Show Side Menu](#) **Search Subject Areas & Legacy Documents:**

Subject Area: **Critiques**

# 1. Scheduling Critiques

Effective Date: **March 2000**

Point of Contact: [Quality Programs & Services Office](#)

## Applicability

This information applies to Line Managers, Critique Leaders, and Critique Team Members when BNL procedures require them to conduct or participate in a critique.

## Required Procedure

Conduct critique meetings as soon as practicable after the event or situation is stabilized, or after a successful special effort is completed, preferably within 24 hours. Staff perform the following steps when scheduling critiques.

<b>Step 1</b>	<p>The Line Manager designates the Critique Leader.</p> <p><b>Note:</b> The Line Manager may be the Critique Leader.</p>
<b>Step 2</b>	<p>The Line Manager determines the level of rigor and comprehensiveness in which to conduct the critique, and charges the Critique Leader on the tasks to be performed, expected outcomes, and time frame for completion.</p>
<b>Step 3</b>	<p>The Critique Leader schedules the time and place for the critique meeting.</p> <p><b>Note:</b> Schedule the critique in a meeting room or at the scene of the event.</p>
<b>Step 4</b>	<p>The Critique Leader invites the following staff, depending on the circumstances:</p> <ul style="list-style-type: none"> <li>• a facilitator (may be the Critique Leader)*</li> <li>• a scribe (to record meeting minutes/notes and prepare the critique summary)*</li> <li>• all staff involved in the event or operation*</li> <li>• witnesses to the event*</li> <li>• a report originator for reportable occurrences such as <a href="#">Radiological</a></li> </ul>

	<p><a href="#">Awareness Reports</a> (RAR), Occurrence Reporting and Processing System (ORPS), and Noncompliance Tracking System (NTS).</p> <ul style="list-style-type: none"> <li>• appropriate subject matter experts</li> <li>• supervisors of the staff who were involved in the event or operation</li> <li>• the Brookhaven Site Office (BHSO) facility representative.</li> </ul> <p>* Required team members</p> <p><b>Note:</b> The <a href="#">Critique Leader's Checklist</a> may be used to organize and control the critique process.</p> <p><b>Note:</b> See the <a href="#">Radiological Awareness Reports</a> subject area, <a href="#">Occurrence Reporting and Processing System (ORPS)</a> subject area, and <a href="#">ES&amp;H Standard 1.1.1, Price-Anderson Amendments Act Compliance Validation and Noncompliance Reporting Program</a> for guidance on reportable occurrences.</p>
<b>Step 5</b>	<p>The Critique Leader requests team members to bring relevant items to the critique meeting, such as</p> <ul style="list-style-type: none"> <li>• written personal statements completed by involved staff (if deemed needed by Line Manager or Critique Leader)</li> <li>• procedures or other documents that control the work related to the event</li> <li>• supporting materials such as documents, records, photographs, design drawings, logs, and parts, as appropriate.</li> </ul> <p><b>Note:</b> The <a href="#">Witness Statement Form</a> from the <a href="#">Investigation of Incidents, Accidents, and Injuries</a> subject area may be used as a tool for written personal statements.</p>

## Guidelines

Review of, and familiarization with, this procedure is sufficient to qualify the Critique Leader for the roles and responsibilities of the critique process. It is recommended that personnel either observe or participate in a critique conducted using this procedure prior to an assignment as a Critique Leader.

## References

[Occurrence Reporting and Processing System \(ORPS\)](#) subject area

[ES&H Standard 1.1.1, Price-Anderson Amendments Act Compliance Validation and Noncompliance Reporting Program](#)

[Investigation of Incidents, Accidents, and Injuries](#) subject area

[Radiological Awareness Reports](#) subject area

| [Continue to Next Page](#) |


[Back to Top](#)

[Back to Top](#)

**The only official copy of this file is the one online in SBMS. Before using a printed copy, verify that it is the most current version by checking the document effective date on the BNL SBMS website.**

1.6-092004/standard/0y/0y01d011.htm

Send a question or comment to the [SBMS Help Desk](#)  
[Disclaimer](#)



[Forms](#)
[Contact List](#)
[SBMS Instructions](#)
[Help Desk](#)

Find Subject Areas:  Categories

[Show Side Menu](#) Search Subject Areas & Legacy Documents:

Subject Area: **Critiques**

## 2. Conducting Critiques

Effective Date: **March 2000**

Point of Contact: [Quality Programs & Services Office](#)

## Applicability

This information applies to Line Managers, Critique Leaders, and Critique Team Members when BNL procedures require them to conduct or participate in a critique.

## Required Procedure

<b>Step 1</b>	<p>The Critique Leader convenes the meeting and gives an overview of the critique process to the team.</p> <p><b>Note:</b> The <a href="#">Critique Leaders Checklist</a> may be used to organize and control the critique process.</p>
<b>Step 2</b>	<p>The facilitator ensures that the team collates the facts and establishes the chronology of the event.</p> <p><b>Note:</b> The <a href="#">Events and Causal Factors Chart</a> may be used as a tool to facilitate establishment of the event chronology.</p> <p><b>Note:</b> The facilitator ensures that the team does not attempt to "problem solve" at this stage of the critique process.</p>
<b>Step 3</b>	<p>The critique team analyzes the event after the chronology is established. As determined by the charge of the critique given by the Line Manager, the team may</p> <ul style="list-style-type: none"> <li>• discuss the causal factors, using the <a href="#">Cause Codes</a> exhibit in the <a href="#">Occurrence Reporting and Processing System (ORPS)</a> subject area,</li> <li>• identify the potential lessons learned (see the <a href="#">Lessons Learned</a> subject area),</li> <li>• develop recommended corrective actions,</li> <li>• recommend roles and responsibilities for carrying out any appropriate follow-up activities.</li> </ul> <p><b>Note:</b> A critique is not intended to be a substitute for a formal root cause analysis required for certain reportable events, although causal factors are identified and discussed.</p>
<b>Step 4</b>	<p>The Scribe and Critique Leader prepare the draft critique summary.</p> <p><b>Note:</b> Use the <a href="#">Critique Summary</a> form to help organize and document the critique results.</p>
<b>Step 5</b>	<p>The Critique Leader validates the results of the critique by distributing the draft critique summary to the team members. all non-team persons named in the draft critique summary. and the Line</p>

	Manager for simultaneous review and comment.
<b>Step 6</b>	The Critique Leader reviews the comments, makes necessary corrections to summary as appropriate, and incorporates the summarized comments into a final critique summary. The Critique Leader signs the final critique summary.
<b>Step 7</b>	The Critique Leader appends all documentation prepared or gathered during the critique process to the final critique summary and forwards the report to the Line Manager with a recommended final distribution.
<b>Step 8</b>	<p>The Line Manager determines the distribution of the final report. Additional reporting may be necessary (see, for example, the <a href="#">Radiological Awareness Report</a> subject area, <a href="#">Occurrence Reporting and Processing System (ORPS)</a> subject area, and <a href="#">ES&amp;H Standard 1.1.1, Price-Anderson Amendments Act Compliance Validation and Noncompliance Reporting Program</a>).</p> <p><b>Note:</b> The Line Manager forwards final reports to the Independent Oversight (IO) Office for review.</p>
<b>Step 9</b>	The Line Manager determines which follow-up activities recommended by the critique will be performed and ensures implementation accordingly.
<b>Step 10</b>	The Line Manager owns and maintains all critique records pursuant to the BNL records management program (see the <a href="#">Records Management</a> subject area).

## Guidelines

Staff are encouraged to document noteworthy management practices and successful work activities that have incorporated new or unique engineering or administrative controls in the [Lessons Learned](#) subject area.

## References

[Occurrence Reporting and Processing System \(ORPS\)](#) subject area

[ES&H Standard 1.1.1, Price-Anderson Amendments Act Compliance Validation and Noncompliance Reporting Program](#)

[Lessons Learned](#) subject area

[Occurrence Reporting and Processing System \(ORPS\)](#) subject area

[Records Management](#) subject area

[Radiological Awareness Reports](#) subject area

| [Go to Previous Page](#) |

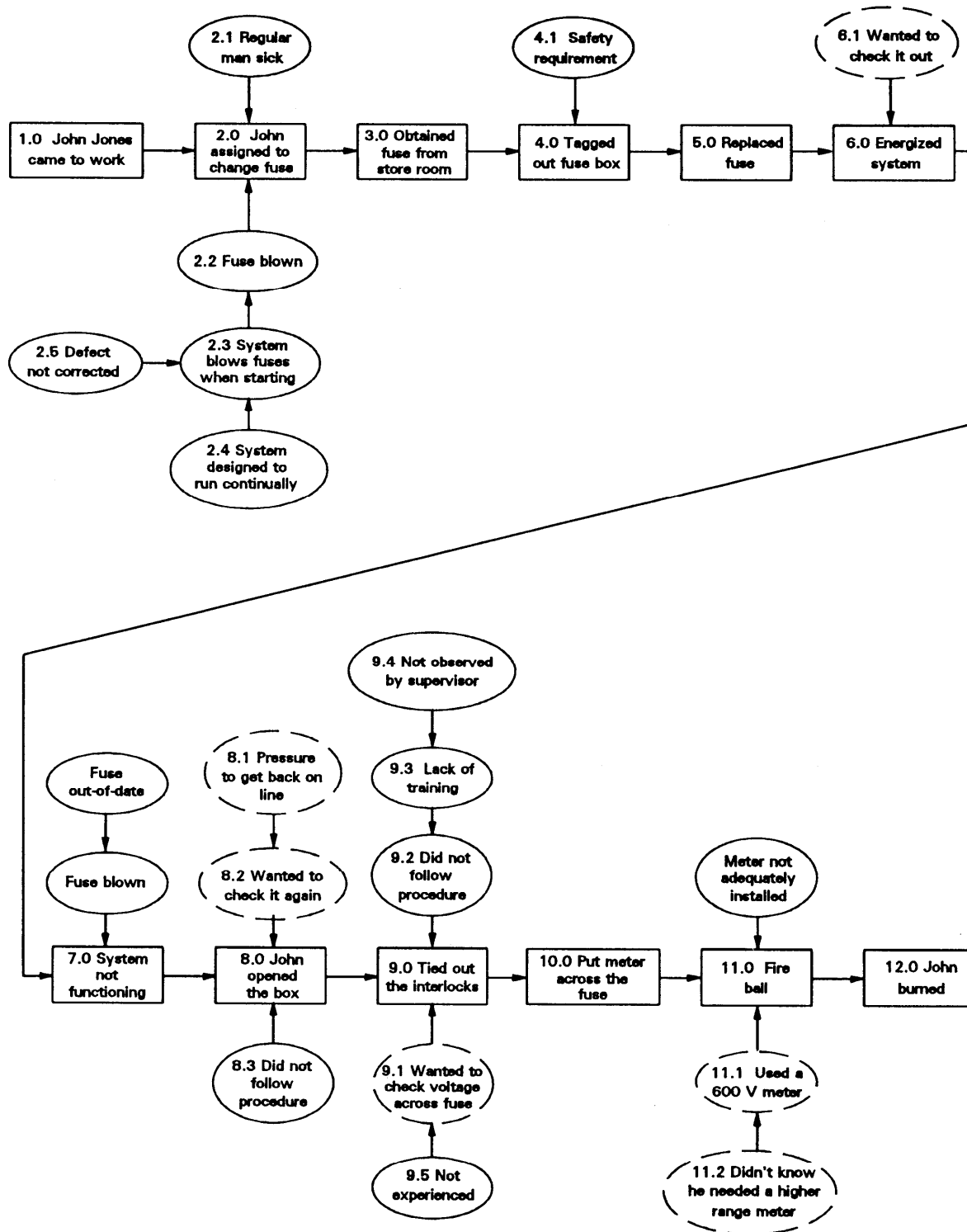
[Back to Top](#)

**The only official copy of this file is the one online in SBMS. Before using a printed copy, verify that it is the most current version by checking the document effective date on the BNL SBMS website.**

1.4-092001/standard/0y/0y02d011.htm

Send a question or comment to the [SBMS Help Desk](#)  
[Disclaimer](#)

# EVENTS AND CAUSAL FACTORS CHART



## Critique Leader's Checklist

<b>Critique No.:</b>			
<b>Name of Critique Leader:</b>			
<b>Date and Time of Critique:</b>			
<b>Description of Event:</b>			
 <b>Date and Time of the Event:</b>			
<b>Identify Occurrence Report Number (e.g., ORPS, NTS, etc.), if applicable:</b>			
<b>Report Originator, if applicable:</b>			
<b>Critique Item</b>	<b>Completed</b>		
	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<b>PREPARE FOR CRITIQUE MEETING</b>			
1. Invite the following to the critique, as applicable:			
• Facilitator (may be Critique Leader)*			
• Scribe (to record meeting minutes/notes and prepare critique summary)*			
• All staff involved in the event or operation*			
• Report originator, if appropriate			
• Appropriate subject matter experts			
• Supervisors of the staff who were involved in the event or operation			
• The DOE/Brookhaven Group (BHG) facility representative			
<i>* Required team members</i>			
2. Instruct team members to bring the following items, as appropriate:			
• Work procedures or other documents that control the work related to the event			
• Written personal statements			
• Other supporting materials such as other documents, records, photographs, design drawings, logs, parts, etc.			
<b>CONDUCT CRITIQUE</b>			
3. Give Overview of Critique Process to Team Members:			
• Distribute meeting agenda			
• Introduce team members			
• Describe critique purpose (i.e., fact-finding, not fault-finding)			
• Give charge/scope of critique (expected tasks, outcomes, and completion time)			
4. Establish Chronology of Event:			
• Prepare a chronology of individual events leading up to and following the main event			
• For a successful special event, identify special operations that made the success			
• Ensure that this part of the critique does not involve development of methods to "solve the problem."			
5. Analyze the facts. Include the following, as appropriate:			
• Identify the causal factors			
• Identify any lessons learned			
• Develop recommended corrective actions			
• Recommend roles and responsibilities for carrying out follow-on activities			
• Identify possible further improvements for a successful special event			
<b>VALIDATE CRITIQUE RESULTS</b>			
6. Prepare draft critique summary and distribute for review and comment. Include:			
• Line Manager			
• All Team Members			
• All non-team persons named in the draft critique summary			
7. Prepare final critique report:			
• Make appropriate corrections to summary			
• Incorporate summarized review comments into summary			
• Sign final critique summary			
• Compile all documentation prepared or gathered during the critique into a final critique report			
<b>CLOSEOUT CRITIQUE</b>			
8. Forward final critique report to Line Manager with recommended final distribution list.			

# CRITIQUE SUMMARY

---

**Critique No.:**

**Date of Critique:**

**Critique Leader:**

**Meeting Participants:**

---

**Brief Event Description:**

---

**Reference Materials** (e.g., work procedures, written statements, etc.):

---

**RELEVANT FACTS AND DATA ASSOCIATED WITH THE EVENT**

(e.g. event chronology, work activities at variance with governing documentation, etc.)

---

**ANALYSIS OF RELEVANT FACTS AND DATA:**

Probable Causal Factors:

Recommended Corrective Actions:

Recommended Lessons Learned:

---


**Signature:**

---

Critique Leader

---

Date



Forms
Contact List
SBMS Instructions
Help Desk

**Find Subject Areas:**

Index ▼

Categories ▼

Alpha ▼

Show Side Menu

Search Subject Areas & Legacy Documents:

## Definitions: Critiques

Effective Date: **March 2000**

Point of Contact: [Quality Programs & Services Office](#)

Term	Definition
causal factor	A condition or an event that results in an effect (anything that shapes or influences the outcome). This may be anything from noise in an instrument channel, a pipe break, an operator error, or a weakness or deficiency in management or administration.
critique	A review of an event conducted by all involved parties for the purpose of fact-finding and identifying lessons learned. A critique is a convened meeting held as soon as possible after the event to identify what happened, but not to assign blame or find fault. A critique may or may not include the identification of action items and recommendations.
event	A real-time happening (e.g., pipe break, valve failure, loss of power). An event may be a single happening or a combination of small happenings that show a trend toward a significant underlying problem.
report originator	The person responsible for preparing a legally-required report.
root cause	The cause that, if corrected, would prevent recurrence of this and similar events. The root cause does not apply to this event only, but has generic implications to a broad group of possible events, and it is the most fundamental aspect of the cause that can logically be identified and corrected. There may be a series of causes that can be identified, one leading to another. This series should be pursued until the fundamental, correctable cause has been identified.
scribe	The person assigned to take meeting minutes/notes and prepare a meeting summary. A scribe is an independent party to the event.

[Back to Top](#)

**The only official copy of this file is the one online in SBMS. Before using a printed copy, verify that it is the most current version by checking the document effective date on the BNL SBMS website.**

1.4-092001/standard/0y/0y00l011.htm

Send a question or comment to the [SBMS Help Desk](#)  
[Disclaimer](#)

<b>SBMS</b>	<a href="#">Forms</a>	<a href="#">Contact List</a>	<a href="#">SBMS Instructions</a>	<a href="#">Help Desk</a>
-------------	-----------------------	------------------------------	-----------------------------------	---------------------------

**Find Subject Areas:**

[Show Side Menu](#) **Search Subject Areas & Legacy Documents:**

---

**Revision History: Critiques**

Point of Contact: [Independent Oversight Assessor](#)

---

## Revision History of this Subject Area

Date	Description	Management System
March 2000	This is a new subject area that provides guidance for conducting critiques of events involving industrial safety or hygiene, conduct of operations, and/or areas of general programmatic breakdown. Staff are also encouraged to use the critique process to document noteworthy management practices and uniquely successful projects/work activities.	Quality Management

[Back to Top](#)

**The only official copy of this file is the one online in SBMS. Before using a printed copy, verify that it is the most current version by checking the document effective date on the BNL SBMS website.**

1.0-032000/standard/0y/0y00a011.htm

Send a question or comment to the [SBMS Help Desk](#)  
[Disclaimer](#)